Mental Health Medication Advisory Committee Meeting Meeting Minutes, Open Session September 1, 2015		
MHMAC Meeting Minutes, Open Session Curtis State Office Building, Room 530 Topeka, KS September 1, 2015	**Members Present:** Vishal Adma, MD, MS, CMQ, CPE Holly Cobb, NP Charles Millhuff, DO Taylor Porter, MD Rebecca Klingler, MD Karen Moeller, PharmD, BCPP Nicole Ellermeier, PharmD Susan Mosier, MD, MBA, FACS, KDHE Secretary/MHMAC Chair **KDHE Staff Present:** Kelley Melton, PharmD, KDHE/DHCF Liane Larson, PharmD, MPH,KDHE/DHCF Carol Arace, KDHE/DHCF	**Representatives:** Jonalan Smith, Sunflower Health Plan; Roy Lindfield, Sunovion; Mike Larkin, KPHA; Bill Clark, Sunovion; Nancy Perry, HP; Colin Thomasset, ACMHCK; Kyle Kessler, ACMHCK; Katherine Friedebach, Sunflower; Amy Campbell, KS Mental Health Coalition; Terry McCurren, Otsuka; S. Shoyinka, Sunflower; Nikki Gilliland, KDADS; Sheena Smith, KHI; Scott Brunner, KHI; C.Eric Harkness, Citizen; Susan Zalenski, Johnson & Johnson; Chris Beil, Otsuka; Jennifer Murff, United Healthcare; Janelle Keller, KDADS; Mary Jo DeFlorio, Janssen; John Esslinger, UHC
	DISCUSSION	**DECISION**

		AND/OR ACTION
I. Call to Order & Announcements	Opening Secretary Mosier called the meeting to order at 10:08am. Secretary Mosier: Alright. Well we'll go ahead and get started. This inaugural meeting of the Mental Health Medication Advisory Committee and first we want to do introductions around the table and then we'll go through basically the process and protocol for the meeting. Introductions I am Dr. Vishal Adma, I am the president of the Kansas Psychiatric Society and a board certified psychiatrist and also the medical director for KVC psychiatric hospitals. I've been a graduate of KU Medical Center for over 16 years. I am Nicole Ellermeier. I am a pharmacist. I work with Med Trak in Overland Park. Prior to that I spent 6 years working with the Kansas DUR Board. I am Holly Cobb. I am a nurse practitioner. I have just finished working at Valeo in their primary care and recently just opened a practice with Dr. Jennifer Harader. Hi. Chip Millhuff. I'm a child psychiatrist, board certified child psychiatrist here in Topeka. I work at Family Service and Guidance Center. I trained at Menninger here in Topeka and have been practicing child psychiatry almost 20 years. Susan Mosier. Secretary of KDHE also an ophthalmologist by training; practiced 12 years in Manhattan Kansas. I'm Becky Klingler. I am a general pediatrician in Manhattan Kansas and a graduate of KU. Hi. Taylor Porter. I'm a board certified psychiatrist working as medical director at Valeo Behavioral Health here in Topeka. Graduated from Portsmouth Naval Hospital; my residency 1991. I'm Karen Moeller. I'm a pharmacist. I'm also board certified in psychiatric pharmacy. I'm a clinical associate professor at the University of Kansas. I also work the impatient unit at KU Medical Center for 13 years. I'm Liane Larson. I'm a pharmacist with Kansas Medicaid. Kelley Melton; also a pharmacist with Kansas Medicaid.	

	Sec. Mosier: Thank you all very much. I wanted to go through what our process will be for today. And so one of the things that we'll do is we have three prior auth. criteria for you today and we'll go through each of those. Liane and Kelley will present the criteria that have been proposed and there will be time for public comment and committee discussion. After that, if there seems to be an interest in moving forward with a particular criteria then we will go through a roll call vote for that. The process will be that it will go through this group to the Drug Utilization Review Board. The Drug Utilization Review Board meets quarterly. They meet on the second Wednesday of the beginning of each quarter. October 14 will be the next meeting. The DUR board can only do one of two things; they can accept it or reject it and send it back to us with comments and we can look at it at the next meeting and see if we want to make any changes or not move forward with it at that time. So that's the process that we'll be going through. What I'd like to do is start with the use of Multiple Concurrent Antipsychotics. Liane.	
II. Use of Multiple Concurrent Antipsychotics	Dr. Larson: The first one we have here is for any type of concurrent use and it's split up both between adults, which you will see here, and I'll scroll down and also under 18. Includes typical and atypical antipsychotics. The criteria that we have here: **CRITERIA FOR PATIENTS ≥18 YEARS OF AGE RECEIVING MULTIPLE ANTIPSYCHOTICS CONCURRENTLY FOR 60 DAYS:** • Three or more antipsychotics used concurrently for greater than 60 days (includes LAI and Oral): o Must be prescribed by a psychiatrist o Peer-to-Peer consult with health plan psychiatrist, medical director, or pharmacy director must be completed for approval • Two or more concurrent long-acting injectable antipsychotics for greater than 60 days o Peer-to-Peer consult with health plan psychiatrist, medical director, or pharmacy director must be completed for approval **LENGTH OF APPROVAL:** 12 Months **CRITERIA FOR PATIENTS <18 YEARS OF AGE RECEIVING MULTIPLE ANTIPSYCHOTICS CONCURRENTLY FOR 60 DAYS:** • Two or more antipsychotics used concurrently for greater than 60 days (includes LAI and Oral): o Must be prescribed by a psychiatrist o Peer-to-Peer consult with health plan psychiatrist, medical director, or clinical pharmacist must be completed for approval **LENGTH OF APPROVAL:** 6 Months	No formal action was taken on the proposed criteria.

Sec. Mosier: Do we have any public comment?

Dr. Melton: Yes, there is one.

Sec. Mosier: That's William Clark with Sunovion?

Public Comment

Mr. Clark: After reading the criteria I'll concede my time back to the committee.

Sec. Mosier: Ok. Thank you. Alright, then it's open for discussion. Yes, Dr. Porter.

Board Discussion

Dr. Porter: I hope people will forgive a little bit of a digression in that this is our first time to talk about our purpose here. And I wanted to see if my understanding is our only thing we're focusing all our decisions on is patient safety.

Sec. Mosier: Right.

Dr. Porter: That's correct then? Ok. The reason we're doing this, of course the legal, it's part of a law change, is to keep patients safe. As I recall the discussions there were concerns in that this state showed higher rates of some of the things we are talking about today than some other states. I think given the expense and effort and everything we're going to put in and all the hard work we're going to do to work this out; is there any additional stuff, any additional data about patient safety such as actual signs that outcomes are worse in Kansas? Or worse because of these things that are more prevalent here? Do we have anything like that to sort of help us feel the mission?

Sec. Mosier: Right. We do have data. Some that was presented in testimony. Do you have some of that?

Dr. Larson: We do have some numbers in terms of more raw data. How many people would meet these particular criteria.

Dr. Porter: But as far as their clinical outcomes, we're not really, there have been more health problems, or worse outcomes, we don't have anything like that?

Dr. Larson: I don't specifically have that.

	Dr. Porter: Ok. We're going to proceed anyway. I just thought that might help a little. I wanted to point out that we're going to talk about a group of patients, Medicaid recipients, who are going to almost, especially the adults, I'll refer to my child colleagues on the other, but especially the adults are going to be seen almost exclusively in mental health centers. As we go forward, we should keep in mind that it'll be a very limited number of clinic patients; we know the numbers of them, they're all on the roles; but the providers, there's going to be a limited number of providers, are basically mental health center employees, and we're having a bit of a tough time staffing some of the mental health centers and I think we should probably be mindful; have attention to the burden of the process we're discussing; but the other thing I'd like to say is that I think the criteria, the things that you're pointing out as concerns, I think are reasonable things to be concerned about. And I think that for somebody to be on 3 antipsychotic medications, the patient and the physician should have really thought this out. And it should be a thought out thing and it should be a well-documented thing. And I think that we as physicians could be better at both those, honestly. The main concern I have, in speaking to a couple of colleagues, every colleague I've spoke to, it's not so much the criteria, as to the proposed process. A peer-to-peer consult is phone tag. We've done this with other insurance companies, we have to back and forth, back and forth, you finally schedule a time, and it'll be a time in which I won't be able to see; it will decrease access for the mental health center because I'll have to schedule time to do this. And at the end of it I end up talking to somebody telling them; hopefully if I thought this out and documented it, hey, yea, this is odd, but the patient is doing better because of this, or I'm afraid they will become destabilized if I change it and then plan provider will decide whatever they decide, but I will have said pretty much that every time I call them. So I would, I have an idea for a different process, but I think I've probably talked enough for my opening statement. Those would be my thoughts. Sec. Mosier: Actually, why don't you go with your proposal. Dr. Porter: Again, I think this could actually help, because I so think there are times, because of various factors on the clinician side, maybe we haven't thought it through enough. Maybe we haven't. And this draws attention to, 'hey you've got someone on 3 antipsychotics, how much does this make clinical sense?' Is a reasonable question. So again, I think some form of this could prompt us to think about it and again documentation is key for a lot of reasons. I got a thing in the mail from one of the MCOs. Which is actually a good example of what I think would be a more useful model. It's from a Dr. Harold who works for, pardon me, I think, Cenpatico, from one of the MCOs, anyway, she's pointed out that I had a patient on 2 antipsychotics and 2 antidepressants and actually it's a real ill guy, schizophrenia, still very ill despite all this, she brought up something about one of the meds for me to think about that I don't think is going to make a big difference, but it's a reasonable thing. She just sent me a letter, she has access to the records because she with for the company, and she just sent me something 'does this make sense, or would you consider doing something different?' and to me that's useful. And there's no phone call, and it's still addressing the potential safety concern. That's the kind of process. Now I suppose if you want it to be more, to have more teeth, you could make sure in the end, they could of course say, if I don't present some reasonable explanation, via letter, via reply, they can insist on change in treatment. I think this process is one, the MCOs have access to the	

clinical records, so if we're documenting properly, we're thinking and documenting properly, there shouldn't be a need for this phone call that is really going to interfere with mental health centers ability to give access to patients.

Dr. Millhuff: I agree with what you are saying Ty, I have had similar kind of calls. It's nice when the review has already seen the chart, they've read your notes, they say, where are you at with this, why are they on 5 medicines, this is how we got here and this is what we've tried. I'm more interested in having a discussion with a fellow child psychologist, that has similar experience and discuss the case, but doing that with every one of these kids, is a hard thing. When I think about that, every kid, I know we're going to get to some other protocols here but it just seems overwhelming to try and set up and do all the paperwork that goes with getting these approved.

Sec. Mosier: It looks like we've identified, so far, a couple of things for further discussion. One is kind of to reduce the burden on the psychiatrist and other health care professionals and then the other is potentially the numbers on the 2 or more, the 3 or more, because you clearly have used an example of 5, so there may be a different number that makes sense too. So especially with your, since this is 18 and under, your experience in child psychiatry, do you have a kind of proposal in either of these areas?

Dr. Millhuff: You mean for the use of more of a number of antipsychotics? Well when we get to the other part of this, some of the other prescribing limits with the younger kids, I have more comments. But I think I'll just hold right here.

Dr. Porter: Dr. Mosier, if I may, I might clarify; the burden, you know I say doctors, we're spoiled, I'm not worried really specifically the burden on me, I can spend my time doing anything but the issue would be more one of access for the patients in the strapped system and if I'm busy on the phone doing this, I can't see a patient at that time. And that decreases access.

Dr. Mosier: Right, I understand.

Dr. Porter: It's a fine point, but I think an important one. I would add one other thing, the language always says psychiatrist, and a lot of the prescribers in Kansas are nurse practitioners and I think maybe some PAs as well, so we probably want to make sure that was clear as we move forward.

Dr. Millhuff: I will say, I'll add a comment. I like to go to this academy meeting, American Academy of Child and Adolescent Psychiatry Psycho Pharm meeting every year. This dilemma of being, having, multiple antipsychotics, 2, at least 2, you are sort of stuck in this in-between phase, where you're transitioning over and they're suddenly much better and of course, I think, we're all trying to use the least number of medicines as necessary. But one of my reactions to the time limit is, I agree with Ty, is that it's probably a good idea to get notification. It's been this long. You've had this person on these medicines, 2 or more medicines, but we can

take it away and see if they do better, but if they start to unravel, you're sort of stuck with this kind of situation. My point is I think this is a very common dilemma that even child psychiatrists see with trying to find a stable regimen and you wind up finding, using 2 of the same category of medicines.

Ms. Cobb: To speak to Dr. Porter's point that the language does read 'Must be prescribed by a psychiatrist'; I don't know if that means a collaborating physician is covered.

Sec. Mosier: And that was specifically for the 3 or more agents use. So it's when we're getting into the use of multiple antipsychotics that, I think, we would be in a consultative relationship. Making sure that we were involving a psychiatrist at that point in time.

Dr. Porter: Instead of the Nurse Practitioner who's managing the case?

Dr. Moeller: Probably should be if Nurse Practitioners or a PAs, make sure you are under; have a Psychiatrist.

Dr. Porter: I thought it was like a clerical error, an oversight, not a planned thing.

Dr. Mosier: Ok.

Dr. Porter: I don't know, has everyone thought about the mid-levels and decided they didn't want them to require review or just didn't put them on there.

Dr. Larson: This could be only for, so if you had an adult, who was on 3 or more, it was intentional, that it's prescribed by a psychiatrist at that point in time. Which is the proposed criteria that was brought to the group. So, yes, required by a Psychiatrist.

Dr. Porter: My further comments would be stronger regard to, it's not about my personal work and so many hours, there's 8 or 9 Nurse Practitioners and one Psychiatrist, and they're the ones that know the cases and clinical data up front. And they are independent licensed practitioners; they are allowed to prescribe medication. I think if there is going to be some kind of review requested it should be with the people that are seeing the patient directly. That's my opinion. There's other voices here, obviously.

Dr. Melton: The situation we are really looking to avoid in making it specific to a Psychiatrist is that if you do really have a complicated case where they are on 3 or more antipsychotics that they are seen by a Psychiatrist. That this is not a Primary Care Physician or any Nurse Practitioner that's not practicing under a Psychiatrist. So if that is something that we need to capture in the language, we could do that. Like Dr. Moeller suggested, potentially say: 'A Nurse Practitioner working under a Psychiatrist'.

Dr. Porter: Sure. That would be fine. Again, almost all of these cases are going to be mental health center

	cases. Dr. Moeller: If you don't have that language it could be like a family clinic. Dr. Porter: I just think that to include the other people that see most psychiatric patients, Nurse Practitioners; I think there's a couple Psychiatric PAs in the state also. Dr. Larson: So would it be acceptable if it was to say like a Nurse Practitioner, PA, Physician working in consult with a Psychiatrist? Dr. Porter: Yeah. I think every one of the Nurse Practitioners and PAs by state law has a collaborative relationship or a supervisory in the case of PAs with a Physician and I think they would need to be psychiatric; I think psychiatric specialist would be what we would be wanting. Ms. Cobb: Yeah, I think the appropriate language would be 'in collaboration with'. Dr. Adma: Part of the challenge, I think, in this process is this is new. Anytime we have something new, there's always concern of what this would do. Number 1; the committee members, I'm not sure how many of us are clear about the number of patients who are receiving these kinds of therapies. Three or more for extended periods of time. Not sharp tongue, because it, it says 60 days, right? Does give some leverage. We really need to understand what is happening. Because, obviously they have the data, we don't. I think it would be helpful for the committee to understand the depth of the problem before we say this is what we need do. We are all in there for patient safety and right patient care. There are outliers of physicians, primary care doctors, psychiatrists, nurse practitioners, who are prescribing wrong treatment for prolonged periods of time then that's a problem and I think it is only fair for the committee members to understand what's happening by the way of data, numbers, which we don't at this time. Because we only think 'our practice'. We are practitioners; we only think about our practice. I think this is a country wide movement, this is not just Kansas, in terms of how do we solve this problem of patients receiving multiple antipsychotics. Now what I see different here compared to some of the other places is, they've combined the typical and atypical all together. You know obviously sometimes atypicals are separated out because of the cost. Typicals are less expensive than atypical. But I think what I see here with the group of studies; mix them all together, because the thinking I guess on their part might be you know, anytime you have multiple atypical or typical antipsychotics being prescribed. I agree in terms of must be prescribed by a psychiatrist versus, you know, having a nurse practitioner practicing under the guidance of a psychiatrist, might be a good thing to have. Anytime you have a psychiatrist supervising, say, a nurse practitioner, we always want to collaborate with them on these difficult cases anyway. So those are a few of my comments. Dr. Larson: I do have some information in regards to that. In putting together the criteria, I tried to look at many states in the surrounding area. So just to give you an idea on that. For the PA for 2 antipsychotics under	

	the age of 18, the other states that have implemented this in our area; Iowa has it, Missouri, Nebraska, and Arkansas. For the 3 or more for adults, actually Missouri has it for 2 or more on adults as well. Iowa also does it and Texas does it for 3 or more. To just give you an idea of what's going on and that's for Medicaid. Dr. Adma: So compared to the fifty states, it's a very minority of patients. Dr. Larson: Yeah, I only looked in our area right here. I did not look across the entire country. I do not have any data in terms of data for how many we had for 3 or more over the age of 18; however we did pull data, able to get it, for under age 18, to give you an idea of the amount of burden, for the first quarter of this year under the age of 18… Dr. Adma: Let's go with the adults. The adults over 18, what's the data? Dr. Larson: I wasn't able to get that for the three or more. I only have it for the under 18. Dr. Adma: Ok. Go ahead. Dr. Larson: Yes, so for the under 18, on 2 or more antipsychotics greater than 60 days, for the first quarter we are estimating it was about 500 under the age of 18. Dr. Adma: 500 patients? Dr. Larson: 500 patients. Dr. Klingler: That's 3 or more not 2 or more? Dr. Larson: That's 2 or more, under 18. Dr. Adma: Under 18, that includes: under 6 and 7 to 13 then? Dr. Larson: Yes, that's all because the criteria on this particular one was written for patients under the age of 18 receiving multiple antipsychotics. So that the amount that fell into that category was approximately 500 the first quarter. Now we don't expect that, looking at our data, we don't expect it to be 500 every quarter. So it wouldn't be like 2000 over the course of a year. We expect a lot of that 500 from the first quarter to fall the same for the second quarter. So I wouldn't be able to say what it would be for a full year. Dr. Adma: 500 out of the total prescriptions of what? Dr. Larson: 500 out of…	

	Dr. Melton: Our total population is around 425,000 people. Dr. Adma: So what percentage is that? Dr. Melton: .1%. Sec. Mosier: But you're talking 500, under the age of 18. So we need under? Because you did total population. Dr. Melton: Our peds would be 260,000 under 18. Dr. Adma: Our pediatrics are? 260K? Dr. Melton: 260, 000, yes. Dr. Klingler: So to put it in practical numbers that's 500 phone call contact combinations that are going to have to be made in just a quarter. Dr. Melton: The approval length of the prior authorization, as proposed, is, for the peds, it's 6 months. Dr. Adma: So everything based on your numbers is 500 prescriptions in a quarter? Dr. Larson: That's for the first quarter. Dr. Adma: Out of 260,000 prescriptions? Dr. Melton: These are patient numbers. Dr. Adma: Patient numbers. That 0.001%. Obviously we see a majority of those patients. Dr. Melton: I'm not sure how that comes out. Dr. Millhuff: So in three months, I could possibly write; maybe are you saying then, could an individual patient been counted more than once? Dr. Larson: No, that was unduplicated. Dr. Millhuff: Ok and do you have data to show the duration in which they were on 2 antipsychotics?	

	Dr. Larson: No. We did not include if they were transitioning, it was a 30 day transition; that was not included. It was only if they were on 2 antipsychotics for more than 60 days. But I don't know if that was the full, if that was for 6 months, or 2 years. Dr. Millhuff: But they had to have been on the 2 for at least 60 days. Dr. Klingler: Do you have prescribing information: how many of those prescriptions are coming from primary care versus psychiatry versus mid-levels? Dr. Larson: I do not at this time. Sec. Mosier: We do have that from a 2008 study. So we can give you that from Kansas Medicaid. Dr. Moeller: Is it that most people are more concerned about the less than 18 years of age, because to me the greater than 18 for 3 or more antipsychotics, I mean that does seem very alarming to me. You can possibly justify 2. I mean going to 3 for longer than 60 just really does seem like a health consequence. I was just trying to see what we're trying to really focus; it seems a lot of it is under 18. What are people's thoughts on the greater than 18? I like it as it is. Dr. Porter: I think there's a reason that it would need to be explained. Main reason to be that the patient has benefited. And the patient would have a deficit if you changed it. Because it is odd. I just happened to have a lady walk into my office yesterday that I re-inherited on 3 and sitting here thinking 'How would I?' other than she said they make her a little better and she doesn't want to stop them. But that's just an example. It happens; really what it comes down to is schizophrenia is really bad. It's a really bad illness. And our medicines, when you look at a drug in a clinical trial, a drug is considered successful when reduces the symptoms by 20%. And that's within its dose range. But it's another thing to sit in a room with a patient or their family and say to them 'You're 20% better, that's good, and 20% enough. 20% might keep you out of the hospital.' Which is kind of where we go when SPMI sometimes. But when they are still saying these voices are bugging me and it's that's when you get the next question; what do you do? Do you go above the PDR with the medicine you are on? Which we'll talk about later. Do you add another agent? Or, like Chip was alluding to, you're in the transition process and they're a bit better. And they don't want to change. They and the family and you don't want to change anything. These are the kind of explanations that lead to it. But I do think it's reasonable to expect the clinician to be able to explain it. Because it is, there's no scientific, you never teach that in the class to give somebody even 2 antipsychotics let alone 3. And yet you end up with patients who it does some good for. Dr. Moeller: I am aware. Yeah, cause I work a lot with the patients. So yeah I defiantly agree with the 20%. It's hard to say what do you do, you're 20% better but you're hearing all these voices and stuff. Even the 2 antipsychotics, though there's not much evidence to support for its efficacy. With Clozaril there is some, most studies tend to show more side effects, not actually better efficacy when you get to 2 or more. So 3 or more I	

	really do think you kind of have to explain something. Dr. Porter: It's not an unreasonable category to have to explain. We should explain everything we do really. Dr. Moeller: I know it is a burden; I don't have to make those phone calls. Dr. Porter: I guess as an adult psychiatrist and this is the adult area, I don't really, again, have a problem with being with having to explain why somebody is on 3 antipsychotics. I think that's a reasonable thing to have to do. I should be doing it anyway. Dr. Moeller: I agree, but what I'd like the 60 days because where there is those times there's the cross thing. And it is scary when you get stuck and they're doing better and you don't want to get rid of, but for 3, 60 days is very reasonable. Dr. Porter: We're going over the thing. For the most part we don't have a big problem with the criteria, again, back to my concern that it's the process. Dr. Adma: It would be nice to have, to know the numbers, for this for us to say yes. Dr. Porter: I know there's one; because I saw her yesterday. She might not be a Medicaid recipient though, might not show up. Dr. Klingler: I guess my last question would be one of procedure on the peer-to-peer consult, is there staff available for the practicing physicians to get a hold of in a timely manner, and to facilitate that discussion. Because it's one thing for the physician to call, but if there's no one on the state end to receive that call in a timely manner, is there staff to accommodate the implantation of this? And that would be my other question. Dr. Melton: And that's why we wrote it the way we did. Initially we had as the Health Plan Psychiatrist. And part of that concern was, you know, the MCOs have a psychiatrist who can work these requests. They have backup psychiatrists but we need to have them be Kansas licensed. And so if there is an urgent case we wanted to be able to appropriate their medical directors or even their pharmacy directors to be able to get cases approved quicker if there's an urgent need. So ideally, and the MCOs agree with us on this, it will be a psychiatrist looking at the cases, but we wrote it specifically this way to address that very concern, that we won't have a review that needs to be done and staff that's not available. Dr. Adma: Whenever there is a peer-to-peer review done, there's always that chance the MCO not agreeing with us. Right? So is there a process in place in case, is there appeal process making sure we still have that leverage to appeal that decision? Is it still that same process or no?	

	Dr. Melton: If you have gone through peer-to-peer consultation process and the MCO still does not agree with the patient's treatment plan, you would still have appeal rights to go through the fair hearing process to explain clinically where you're coming from. Ideally we see it being collaborative. If you and the MCO don't agree on the patients current treatment plan, maybe you're able to find a different option. We really see the fair hearing and the appeal process as being a last resort. Dr. Adma: Ok. Dr. Millhuff: In the process who oversees, I'm very naive to this, so who oversees that the MCOs are following the protocols and so forth like with what you were just saying. To make sure, that we're not just getting everything denied, and we're just sorry, we're sort of going through this nightmare of appeals and paperwork and all this kind of stuff to try and get authorization. Dr. Melton: Liane is kind of our reports guru, so she may be able to better speak to that than me. Dr. Larson: So actually I do get a whole host of reports on a monthly basis. And one of them is specifically is around the PA criteria and how many they are receiving for consideration, how many they are approving, how many their denying. I'm constantly looking at how that's going. I then I can break it down and request information on a drug basis if need be, if we're seeing an issue with it, to then to dive into. So we do get that information on a monthly basis in terms of the PAs as to how many are being submitted, approved, or denied. Dr. Melton: And especially specific to this committee and what we're looking at here we understand that this is going to be a really sensitive process and so we plan to have extra oversight. In terms of when the MCOs implement these, and ideally we'd like almost constant updates. What kind of volume are you seeing? Are you running into any outlier cases? What should be on our radar? Dr. Adma: Is there any middle ground that we can think of where we're going from everything that the physician writes being approved right now to requiring prior authorization, peer-to-peer, versus something in between when anytime the MCOs notice these multiple antipsychotic prescriptions, more of a consultative phone call? Because they have that information. Can they proactively engage in that? That might be the middle ground before we say prior authorization. Dr. Melton: Our MCOs already do that. Dr. Porter: As I mentioned, I have a letter. Dr. Adma: Is that working? Dr. Porter: It makes me think about it. I will consider it, if lowering the Wellbutrin might help with the	

	schizophrenia is reasonable. It's a reasonable thing to think about. Dr. Adma: I get that all the time, even on an inpatient. It's good. If that is working, I guess they might have a different opinion, but if that is working, why change it? Dr. Melton: That's a process we've actually had going back to pre-KanCare. When we were more heavily fee-for-service, we would letter prescribers if we saw something aberrant prescribing wise. For us we're still not reaching the fundamental issue of a patient on a complicated regimen having well-supervised and coordinated care. As we spoke to earlier, we still have no ability to ensure that a patient is being seen by a psychiatrist or their case is being consulted on with a psychiatrist. For a state with a rural population as ours, we see that as, obviously a challenge, but it's somewhat problematic also. We can letter, and we have lettered and we've done prescriber education. There's still just fundamental issues that we would like to be able to address. Dr. Porter: Maybe something like this but with teeth. If you don't; If your records don't indicate you've addressed this concern, the teeth would be the peer-to-peer. We don't want to do the peer-to-peer. Dr. Melton: What if we were able to pull a list of patients that would meet this criteria and letter you in advance. And say, 'in the next 30 days or 60 days this will require prior authorization. So either submit documentation, or look at a regimen change.' Is that something that you feel like that would be? Dr. Porter: Yeah, I think anything again, that just utilizes the fact that we should be documenting our thoughts anyway and just having that reviewed rather than phone tag and basically getting on the phone and telling somebody that I'm doing this because I think not doing it is worse. Please pay for it. It's kind of basically the nutshell how every one of those phone calls will go. I think, yeah, it's much better to just use the records we already have and will prompt us to get our records right if not and then in turn this doctor has me thinking of something in regards to this case. It's not a bad, it's a good thing. It's a review process that could help people be more safe, again remind us to document what we do in a proper way and not decrease access or not nearly as much decrease the access than the phone tag thing would. Dr. Adma: So something like maybe 30 day notification, 60 day notification before prior authorization, is that what you're thinking? Dr. Porter: Yes, I think getting notification would be good. Dr. Ellermeier: I think one thing to recognize is at this table you guys are specialists; you are working in this every day. But what we're talking about the entire population. Not every patient is seeing a psychiatrist or is at a mental health clinic. So I think it's important to take that into consideration, we're not just talking about people that see this day to day.	

	Dr. Porter: We have so much child work to do. And this particular criteria is adult, I think there would be very few people, maybe I guess in rural areas, when there isn't safe access that would be Medicaid recipients in private practice and not seeing a psychiatrist. Where the primary care is prescribing. One reason the primary care isn't doing this is because he's trying to steal the psychiatric business in Goodland, it's because there isn't a psychiatrist. Dr. Klingler: I will tell you in primary care where I see this, because I don't prescribe polypharmacy, I call on Dr. Millhuff, to see a patient. I see this when I get kids that are chronically in foster care with no continuity in care in the mental health arena. I have a ton of kids in front of me. And that's where my concern is. I don't know who prescribing, it's a myriad of people, they may have 5 different medications prescribed by 5 different people and because there's no continuity and I'm calling them, begging them, for psychiatric provider to please see this patient and help me figure out what this patient should be on. As a primary care physician, I speak for myself in primary care not for out in rural western Kansas, where I get involved with this is crisis management and trying to get them into a mental health system that can provide for them comprehensively; and so it's more of a 'I've got all this, what do I do with it, and they need to see somebody.' I'm not sure the polypharmacy is always coming from one provider, as much as with the situations I see and it's very different from the psychiatrists in the room, these kids are coming to me having seen multiple people with no continuity of care and on multiple drugs. I guess that's one of the things I would feel is important to track, is the people that are seeing Dr. Porter, obviously have a plan for polypharmacy, but I think there's kids in our state where the polypharmacy is not intentional and we need to somehow address that more than on the same physician prescribing multiple antipsychotics but the same patient getting multiple things from different people. So it's just a little different on the question of the primary care side. Dr. Millhuff: Well with that in mind, does looking at pediatric polypharmacy, is the problems of that any greater than it what it is in adult populations? She's mentioning foster care, but I can imagine they're adults in certain kinds of settings that they might have this kind of situation. Is it necessarily a bigger problem in a pediatric population? The polypharmacy to an adult population. Dr. Larson: Not being able to pull that adult data with the timeframe, I wouldn't be able to say. Dr. Porter: Adults wander around some, you know the foster system can't change their counties, because of a placement issue, I think that what's get things disrupted and I think adults wonder but they don't get moved around as much, may be one issue. Dr. Moeller: This policy, though, could alert the physician who's taking over at this time that they might not be aware of that they had 2 other prescriptions that they are taking. Because I would assume a new physician would be prescribing a refill, it would alert them. Dr. Porter: Unintentional polypharmacy is most always bad. And I'm not saying intentional is always fantastic,	

	but unintentional will always be an issue. Dr. Klingler: So I guess that's what my suggestion on this would be, greater than 60 days or when these are being prescribed by multiple providers. Because I think that the multiple providers is where we get into challenges with kids going through our foster care system or in chaotic household situations where they move frequently. Dr. Moeller: These would catch multiple prescribers. Dr. Larson: Yeah, so as long as you had a patient under 18 and had one prescription from one provider and one from another it would still catch it as if it was from the same provider. So not matter whoever prescribed it, it would still catch it on this PA. Sec. Mosier: Is there other discussion on this? I kind of want to recap where we are and then see. A lot of great discussion. I really appreciate all the discussion here today. We've talked about an alternative process, and the alternative process potentially being a letter in advance; 30 to 60 days for people that meet these criteria, and that the provider would then provide documentation or potentially change the regimen based on that. We changed the language based on rather than 'prescribed by a psychiatrist' to 'prescribed by a psychiatrist or a health care provider in collaboration with a psychiatrist'. We also had a request for additional data. So kind of based on all of that; what I propose we bring this back with the next meeting with the additional data and those changes. Unless we have anybody that's thinking otherwise. Dr. Porter: My wish would be that when we get the warning letter and need to send documentation, that a clinical document be acceptable. Not necessarily fill out a form to justify. You could send your own note which hopefully says what it needs to say about why you are doing what you are doing. I would propose that as part of that. Dr. Melton: I would assume the health plan, they would be having that reviewed by a psychiatrist; they're able to look at whatever kind of documentation. Dr. Adma: That would really save some time for the psychiatrist. If they are able to accept that clinical document. Dr. Melton: We may need some kind of preliminary form that just has patient, date of birth, that kind of information. I can't promise you there won't be sort of a cover form for you to fill out. I think submitting records would be workable. Dr. Adma: If staff could print out progress note that explains all that and attach it.	

	Dr. Melton: Yes. Ms. Cobb: And I think that would be key, because the process of prior authorizations can be labor and time intensive. And then if you make the effort and you're not talking to the appropriate person it doubles the time involved in that, so the process, it seems, would be really key in this. Dr. Adma: As the physician involved would I get the letter and they need the clarification why the medication regimen, I'll dictate or type in the rationale and the MCOs look at it, I think that would be really helpful. Dr. Melton: In terms of data, I know we talked about looking at, especially for our peds, who is actually prescribing, and getting that adult on 3 or more number, and we could also look at multiple prescribers, especially for the peds. Dr. Porter: I just want to comment about the way things come to pass, and I think this is fine, but what will happen is that somebody will come out of the long term treatment setting and they'll show up in your office on 3 meds, for example, you not really knowing the patient, need to explain it, but the fair part of that, 60 days later, you should be able to explain it. You should be able to agree with the plan. Although a lot of times, even adults move around, we inherit people. We weren't part of the initial process, but the person says it works for them. But I still think it's reasonable. Dr. Millhuff: Just a process question: So let's say the prior authorization happens and for whatever reason, it's denied. What then happens? What happens to the patient? What if they are on 2 antipsychotics, what happens to that person? Let's say they have 3 medicines going, or 2. Dr. Larson: At that point in time if it's denied, they would not be able to get it through Medicaid. It would have to go through the appeals process. Dr. Klingler: So is it the newest one that doesn't get paid? Which one doesn't get paid for? Dr. Larson: It would be for whichever one at that point in time that they are actually at the pharmacy trying to fill. Dr. Millhuff: Let's say they are trying to fill both of them. Dr. Larson: It would be for whichever one that the pharmacy is putting through. It would be third or over. It would just be however it was put in. Dr. Adma: To question it, one might be more expensive than the other?	

	Dr. Larson: No, it wouldn't. Because the way the system works, is the first one the pharmacy put in would not hit this PA. It would be, for instance, the second prescription. It literally would be literally whatever the pharmacy put in as that third one. Dr. Melton: Or if you knew that they were going to the pharmacy and hit the 3 claim limit, and you've got them on say two brand names and a generic; you could tell them to make sure you get your two brand names and your generic we'll figure some way to pay for it. Because if they are on 2, it wouldn't hit the limit. Dr. Millhuff: Unless they're under 18. Dr. Melton: Correct. Dr. Millhuff: We're getting to the foster care thing. A lot of kids are out there on the rotating thing of from blown placement, to blown placement, to blown placement and they can't quite engage in services so you have someone who really hasn't had the chance to have a new plan to simplify and clean up the medicine regimen. What I'm getting at is the risk to the patient of abruptly not getting their medicine. Dr. Melton: What we've talked about with Dr. Mosier's office is right now we've got a 72 hour override for pharmacy where the patient needs a medication and it hits per PA and the pharmacy can do an emergency supply. What we've talked about is extending that window, especially for mental health, to 5 days. And making sure the pharmacy gets paid for any emergency supplies they dispense. That would give us at least a 5 day window to work it out. As you are going through the appeals process you still have access to those services. So if the patient was able to file for an appeal, their case would still be able to go through in that interim period while the appeal is being decided. Dr. Millhuff: You mean they would still be able to receive their medicine? Dr. Melton: Yeah. If a patient files for fair hearing, in that period while the fair hearing is being decided, we can't take away the services. Dr. Millhuff: So they wouldn't have an abrupt cessation of their antipsychotic medicines. Dr. Melton: That's what we would want to avoid in every case. Dr. Porter: There's some language about a 30 day override. That's different than the 5 day? Dr. Larson: That is on a separate criteria. Dr. Melton: We specifically proposed that to avoid these kinds things.	

	Dr. Larson: In pediatric patients. Dr. Porter: Just in pediatrics? Dr. Melton: Yes. Dr. Adma: Are we going on to the pediatric or are we still discussing the adult? Sec. Mosier: We can go to the next one unless anybody has any further comment on the first criteria. Alright. We will go to the antipsychotic criteria for children age 13 and younger. We'll have Liane go over the proposed criteria.	
III. Antipsychotics For Children Age 13 or Younger	Dr. Larson: Ok, this is for antipsychotic for children 13 years of age or younger. This is only atypical antipsychotics. **CRITERIA FOR** ANTIPSYCHOTICS PRESCRIBED TO CHILDREN AGE 6 OR YOUNGER: (must meet all of the following) • Must be prescribed by a psychiatrist • Must have a diagnosis of Autistic Disorder, Hyperactive Behavior, Mood Disorder, Problem Behavior (Severe), Schizophrenia OR Tourette's Syndrome • Documentation of plasma glucose, lipid screening, weight and waist circumference within the previous 3 months **LENGTH OF APPROVAL:** 6 Months* * A one-time 30 day override for this criteria requirement will be available to dispensing pharmacies through the Point-of-Sale PBM adjudication system. The next one: **CRITERIA FOR** ANTIPSYCHOTICS PRESCRIBED TO CHILDREN AGES 7-13: • Must have a diagnosis of Autistic Disorder, Hyperactive Behavior, Mood Disorder, Problem Behavior (Severe), Schizophrenia OR Tourette's Syndrome • Documentation of plasma glucose, lipid screening, weight and waist circumference within the previous 3 months **LENGTH OF APPROVAL:** 12 Months* * A one-time 30 day override for this criteria requirement will be available to dispensing pharmacies through the Point-of-Sale PBM adjudication system. There is specific renewal criteria with each of these:	No formal action was taken on the proposed criteria.

RENEWAL CRITERIA FOR CHILDREN AGE 6 OR YOUNGER: (must meet all of the following)

- Must be prescribed by a psychiatrist
- Documentation of glucose and lipid screening within the previous 6 months
- Patient must be receiving evidenced-based behavioral modification therapy concurrently with anti-psychotic therapy unless behavioral modification therapy is documented to be ineffective
- Annual physical must be completed by a pediatrician for continued approval

LENGTH OF RENEWAL APPROVAL: 12 months

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- Annual physical must be completed by a pediatrician for continued approval

LENGTH OF RENEWAL APPROVAL: 12 months

Sec. Mosier: On this one we did not have any public comment? Is that correct? Ok. So we are open for discussion.

Dr. Adma: Number one again, we are in the area of psychiatrist, nurse practitioner practicing under a psychiatrist and a PA. And obviously there are pediatricians in rural Kansas that are prescribing medications to children right? Prescribing psychiatric medicines to children. How do we deal with that? In terms of the diagnosis. The Hyperactive Behavior and the Severe Problem Behavior are not psychiatric diagnosis so I'm not sure why they included those in this list. When they talk about diagnosis.

Dr. Millhuff: Dr. Adma, could I interrupt you just a second?

Dr. Adma: Yes.

Dr. Millhuff: Dr. Klingler, are you a developmental pediatrician?

Dr. Klingler: No, I'm boarded in general pediatrics.

Dr. Millhuff: You know we see a lot of kids with autism that are seen by pediatricians and developmental pediatricians. Send a lot of our kids to KU for their developmental pediatricians to look at them for autism. I'm wondering if the psychiatrist is getting a little too narrow since two of our antipsychotic medicines are approved for autism. Down even to the age of 5, at least one of them is.

Dr. Klingler: And I would say I don't know how much medication management is done in Kansas City, but Dr. Kerschen and Dr. Allen in Wichita who are development pediatricians definitely use some of those medications in their population of autism. The other note I would make on that, some of the smaller children. We need many more Dr. Millhuffs, we don't have enough pediatric psychiatrists. So we sometimes have such a waiting list we'll use a neurologists to help us. Well use behavioral pediatricians, although there's months and months and months of a waiting list. Dr. Kerschen is 9 to 15 months to get in. So there are some people that are helping to manage these that are not traditionally psychiatrists.

Dr. Millhuff: We'll collaborate on the phone. You'll say "Hey Chip, I've got this person. I want them to see you. What do you think?" And I'll give you, or one of your colleagues, some advice on where I would start. So then you've got the pediatrician, I believe you've got nurse practitioners that will call, people I supervise or consult with and so I think we are getting at how narrow it is to just say 'must be prescribed by a psychiatrist' is a problem.

Dr. Porter: I also see, some of the behavioral, not diagnosed behavior but some of the MR folks don't have a formal psychiatric diagnosis, but at times their behavior is managed. Gets in the hospital and gets some managed on some of these kids.

Dr. Klingler: The PDD-NOS kids.

Dr. Melton: Sometimes the language we use is; 'must be prescribed by or in consultation with', so that may be something we could think about. We could say Psychiatrist or some of these other specialties that you feel would be appropriate.

Dr. Klingler: And I think on the flip side too, on the back page of that where it says 'physical completed by a pediatrician'. Outside of the pediatricians out in Garden and Dodge, there's a dearth of us in western Kansas, but there's probably some family practice doctors that would need to do those physicals also.

Dr. Melton: And what we're trying to get at with that criteria is that sometimes these patients end up just seeing mental health and so there are physical health issues that can go unaddressed.

Dr. Klingler: They should be getting their KBHs.

	Dr. Melton: They should. Dr. Klingler: As required to continue their Medicaid. So that's a requirement already that they should be doing that. And I think that's great, but I do think that there are some communities where we don't have pediatricians. Dr. Adma: I like the idea of documentation of these lipid monitoring, glucose monitoring, weight and waist, all those are good, but what if they refuse? Sometimes kids refuse blood draws. They will for a period of time. We have to have; think about sometimes a refusal of should not lead to medicines not continuing. I think we need to keep trying, but that should not be a limiting factor. I like the 30 day override system, it helps. Certainly it's helpful. For the psychiatrist, Chip you can chime in on this, the annual physicals? It's not under our control, and all we can do is advice. But if that is one of the criteria, we have no control over that. That might be a problem too. Dr. Millhuff: Right. Right. It makes perfect clinical sense, but we're working with family that, with kids that don't cooperate and so forth. Dr. Adma: The therapy part is, it's helpful, but what if they refuse. Does that mean their medications will not be authorized because they refused therapy? Dr. Mosier: You would have documentation of the refusal. Dr. Adma: So it should at least, it says that it was ineffective, which means it was tried, but what if they refuse? Dr. Melton: I understand where you're coming from all those. Those should, ideally, be at the outlier types of situations. This criteria's really built with the goal in mind of, making sure that they are being monitored, that they're getting a physical, that they're getting therapy in conjunction with the medications that they're on. So if we do have exceptions to those general rules, those can be addressed with a peer-to-peer discussion with the health plan. But ideally, this is the standard that we'd like to set. That this, at a bare minimum, is what we would like to be seeing with each of these kids. Dr. Moeller: I do agree. I wasn't sure what Problem Behavior. Is that diagnosis? Dr. Melton: And on the diagnoses, what we were trying to do was; we want to work with you guys, we understand especially for pediatric psychiatrists, that your jobs are really difficult and sometimes you do have to use drugs off label or things that you can find a study for and we are trying to be accommodating of that and trying to have a more broad look at it, of what may potentially be appropriate prescribing. If there's better language that we could use there that you feel would better speak to what actually happens in practice, we're	

	definitely open to that. But that's what we are trying to get at, is to try to be accommodating of the different things you do actually see. Dr. Adma: One of the symptoms, I guess, I don't want to call it diagnosis; aggression is one symptom that we see sometimes that might be related to a mood disorder. Dr. Millhuff: What we see is common, with all of these, commonly the target concern is mood instability and agitation. Mood instability and agitation, mood regulation, have that regulation problems. You'll see that very clearly in the studies that support the use of antipsychotics for autism people. What we see this with kids with mood disorder. The other thing, we've got this disruptive mood disregulation disorder that is coming on board. And it seems with DSM-5 we're going to be capturing even more kids that meet criteria for consideration for these kinds of medicine from a diagnostic standpoint. A lot of these kids have had mood disorder and there are that sort of bi-polar out there and sort of things. But now we have something a little closer to home that we can put in there like autism. But even at that, we're trying to understand what really works for those. That they're new enough on the scene that we're still trying to figure out exactly what's the best way to go about this. You know what I was, just to shift the discussion a little bit, am I reading this right that every person younger than 13 is going to have to have a prior authorization before they get an antipsychotic medicine? Every time I write a script for every new eval, everyone's going to have to go through this prior authorization? All this documentation? Dr. Melton: That is what we were looking for. And again, we feel like, to meet the prior authorization criteria, we were trying to be accommodating, in terms of diagnoses, and then just asking for the minimum that should be being done clinically to monitor for metabolic syndrome and things like that. So, in terms of actual volume of patients, we have data on that. I mean that's a discussion that we could have. But we felt like, again, if the goal is appropriate care for these patients, that all we're are really asking for is a correct diagnosis and monitoring. Dr. Millhuff: Do you have data that shows that prescribing practices, now, in the state of Kansas, are not appropriate for this age group? Dr. Melton: And that's difficult to know because of the whole diagnosis process. We can look at the pharmacy claims and see what medications they've received and when, but we don't have an easy, seamless way to match that up with their medical data and trying to see what diagnoses they've actually got. Dr. Millhuff: Right. Comorbidity is the common thing with many of these kids. So just the billing diagnosis, there's usually other things going on as well. So getting the more comprehensive view, it just seems like this is going to add a tremendous amount of additional administrative work for us when we're already stretched quite thin and the demand is very high. Keep in mind that it's more than just pharmacotherapy that the child psychiatrist is doing, we're also thinking about psychological and social interventions. We're really trying to	

	make the most of our time with our clients. So, if I know in my mind, ok, I've got this autistic child that cannot hold it together at school, they're out of control for instance. Or another child with a mood disorder, I'm going to have to carve out time to get all this paperwork filled out and prepared to give to you to first get authorization rather than getting the script and then sending them out the door to get immediate intervention. A lot of these people are in crisis mode. And I'm worried that this is going to be a cumbersome process. We're going to get immediate denials. And then you're going to get into all this appeals stuff. Dr. Larson: And that's why we put in, also the 30 day override. So if you had someone in that situation, you could write the prescription. They go that day to the pharmacy, and it wouldn't be an issue. Then you would have that 30 days then to provide the documentation before they go back to get the refill. And it would be on the 7 to 13 year old, it would be the diagnosis, and documentation of the plasma glucose, lipid screening within the 30 days. Dr. Ellermeier: One thing, I understand the burden of having to fill out a PA for every patient but I recently just read a study across the entire Medicaid population across the US around the level of, the amount of times the pediatric patients are not being appropriately monitored for their glucose, their lipid, their weight, and the metabolic syndrome. It's quite a disparity, even between adults and children in just the Medicaid population. Dr. Millhuff: In particular, too, when we're talking about elementary school age kids or even preschoolers, you can say, "Ok, I need you to get this lab done." You're doing everything, you're talking about metabolic syndrome, and tardive dyskinesia, you're doing all the informed consent stuff up front, but then it's the matter of them leaving and going and doing it. When you've got them on your unit in the hospital, it's easier because you just do it, because they're there. But yet, when I've got to get these families to follow through, they just plumb don't. Dr. Adma: Then the 30 days comes and go by and that's not done. Dr. Millhuff: I mean, you're right, it doesn't get done. That's sort of like, what's the best solution to safe guarding their situation. Dr. Ellermeier: We know the long terms effects of these drugs on children especially when they aren't monitored. So are we doing them a disservice by not following up and making sure these things are being done? Dr. Porter: What about, most of the kids will step on a scale and I understand that doesn't capture all metabolic information and there's occasional glucose and lipid abnormalities in kids who aren't becoming obese, but the bulk of the metabolic things we worry about are the accompanied by weight gain. These are great criteria, but I wonder if the kid is weighed, and they're not falling off the growth chart and they're refusing, the family won't take them to the lab, they don't want to hold them down; would that be given some consideration if you just	

	have the weight? And again, if they're getting their obese, maybe we do need to be more insistent on the meds or something. Dr. Moeller: Would this be, if they refused it, would that be an option on the prior authorization, where they've talked to somebody and waive it for another 6 months or something? But it's documented that they've refused. That it's been attempted. Dr. Larson: That would be something that, up to the discretion of this group, we could include in the criteria. Dr. Millhuff: But it's also up to the clinician, prescribing clinician, to also to say: 'Look, your BMI is off the charts. I'm very worried about your health and I'm not going to prescribe this to you." Same sort of dilemma with psychostimulants. You know, you see someone that's not going on the growth trajectory and you say; "We've got to stop this." That's when I'm getting on the phone and talking to the pediatrician, and trying to collaborate and then we're getting the Health Homes person to kind of help them. Dr. Porter: Here's what I think might be an option to a little more protection and encouragement but also not take kids of meds that are working. Would be, if we say parent refused and we just have to document that, I'm gonna tell on us. They'll be times some of us might say: "If you really don't want to do this, I'll just put 'parent refused'." And that's not what we're really going for here. We really want to stress how important it is to have these things done. So I would think that maybe, if we're going to include parent refusal as criteria or guardian refusal, because God knows why some of these kids really don't have parents, these particular children we're talking about, that that individual sign a more involved form indicating, because they're deciding for the child not to take them to them lab. So they sign something that's more extensive about they understand the risks and benefits and what and why; put the parent or guardian in the loop if this lab's not getting done. What do you guys think about that as a side criteria? Dr. Moeller: I don't know about the parent refusing as more than it's the child refusing. Dr. Millhuff: Sometimes too it's; 'Oh, I forgot. Oops, sorry, I know you need to get that done.' Dr. Adma: My concern is, number 1, is the 30 days. I mean that's a very short range for us to say you've got to do this. Number 2, I would say probably 60+ percent of our practice is 13 or younger, right? Dr. Millhuff: Correct. Dr. Adma: So which means we would be prior authing or sending this information to anybody who's practicing child psychiatry, in the majority of the practices, 60% of the practice they will need to do prior authorize.	

	Dr. Millhuff: Right. Dr. Klingler: I guess that brings up my question; Does this create more harm than the harm that's already being done. I don't know that I've seen harm with the current prescribing practices. And this obviously from the psychiatrist in the room, has a potential to create the lay of care and harm. And I'm having a hard time figuring out why this needs to exist if there's not a current harm that we see. So I guess that would be my question. My other comment would be; that in the measurements that a recommended height needs to be included in that also. And BMI. Dr. Millhuff: I agree. Because you got to get your BMI which is a more sensitive measure. Dr. Klingler: I don't know the last time I did; I mean weight, circumference I think is fine, but height and BMI. Dr. Porter: I guess we know from the child psychiatrists a lot, but could we also have a number? You have the 500 people/kids on the 2 or more? Dr. Larson: The numbers just in terms of children on the antipsychotics within this; Zero to 6 for the first quarter of this year, we approximated 450 children under the age of 6 including down to the age of 2 years old. And then for 7 to 13, approximately 3,400. Dr. Adma: Wow. You mean this criteria on antipsychotics? Dr. Larson: Antipsychotics, yes. And this was, I don't have any information in regards to prescriber, or how many that is. But that's just, at least, 1 antipsychotics during the quarter. Dr. Moeller: I don't think we all know all the long term risks of being on these as children. It's alarming, that you just said, how many are 2 and under? Dr. Larson: Under 6, 450 approximately and when we did the age range it went down to 2 years old. Dr. Moeller: I mean I can't imagine why a 2 year old would be on this. The risks; are they going to have diabetes, high cholesterol, a lot earlier and are we lowering their life span? We already know that mental illness has a 10 year life span age range to begin with. What are doing to these kids now so that they no longer; it is alarming thinking of a 2 year old being on it. And, you know, I don't work with pediatrics or under 6 years of age, and so I can't imagine why a 2 year old or 3 year old and really justifying it. Dr. Larson: Just to give you more information. I did pull information of other states as on the other one. Out of 7 states, the states that make it requirement for a hard stop PA or manual review with the plan; Arkansas under 6 hard stop. Colorado, Missouri, Nebraska, Oklahoma, and Texas all have hard stops either at the ages of 5 or	

	6 within their PA criteria. Dr. Millhuff: What does that mean? Dr. Larson: That it requires any prescription for antipsychotic under that age; each state has a little bit different; either it require a manual review between, like a peer-to-peer review, or it requires just going through appeals process for under that age. Dr. Millhuff: Can I respond to your comment of having a hard time understanding of why you prescribe this and I think it's very important that these meds be used in the context of decent psychotherapy and other sort of social interventions. We're talking a lot about putting hard stops. I'm kind of wondering, is this really the best way to go about it? I mean, I like the comment about of having behavioral intervention as part of the treatment. In fact I think these kids need to have demonstrated that they have been in some sort of a process, not just a couple sessions, but something that has gone on for maybe 6 to 8 weeks. Not 2 sessions, I mean, maybe 4 or 5, so that there has been an intervention. I think that needs to be emphasized. And then also, we got kids that are coming in that have been in horrible abusive situations or they've had multiple care givers throughout their infancy and they don't attach right and they're extremely aggressive and violent. I think that it is, hopefully the last thing that we do in getting to the medicines as an intervention. Or think of these very, very impaired autistic children that don't sleep. And they've been tried on all kinds of stuff. There's been all kinds of sleep hygiene interventions. They've got the sleep problems, plus they've got the mood instability and agitation and the parents are fried. And this network to support them; they've been kicked out of multiple day care settings; the parents are losing their jobs. You probably know this; you see that in these people; they're desperate. And you are trying to get more support from a psychosocial level in terms of attendant care and respite care and it's hard to come by and so you get to the point where you're sort of like, you try to start low with these medicines and go very cautiously. That's the other thing, dosing guidelines, there's nothing there. Dr. Moeller: I think what you're illustrating is doing it the right way. Dr. Millhuff: Correct. Dr. Moeller: What about the clinicians that grab the antipsychotic first? Dr. Millhuff: Right. Dr. Moeller: And so that's kind of the concern. But you're right. You're saying you've tried all these other different agents and all that, but, we are the specialists here, what about all those people from rural towns. Dr. Millhuff: So someone like me that's really busy with these kids and trying to practice within the practice guidelines and recommendations, it seems like this is a pretty blunt instrument that's going to really change	

	my practice and the number of others that are doing this kind of work. Is it really the best way to go about this? And is there a more effective way to educate and monitor maybe certain prescribers that are not prescribing appropriately, than this kind of method of a prior authorization that affects all of us? Dr. Moeller: Hasn't this been tried in the past? Like letters out, say 'you're prescribing this…'? Dr. Larson: As Kelley stated before, the plans have been sending letters. And going back to the question of whether it's correct prescribing or not, in those 455 patients under the age of 6, don't know. That's what, with this PA criteria, what we're asking is to show, that the prescriber can then say, 'yes, it is correct prescribing.' But at this point in time, we don't know for those 2, 3, 4 year olds, that it is correct because we have nothing in place. Dr. Porter: As we talk about this, again, and I have child psychiatric colleagues, I've covered on the child unit at times in my career, you see these, this sounds pejorative, literally almost feral children. I guess, not literally because they weren't technically raised by animals, or at least, four-legged animals, and they're extremely behavioral challenged, but this'll be a 4, 5, 6 year old child that is violent. Like might go after an infant with a knife. I mean really, really violent children, but on the flip side, we are also talking about 2 or 3; I've never seen it in that age. I don't have any idea, by a child psychiatrist, why a 2 year old would be on the antipsychotic. Because basically a 2 year old, out of control, is not very dangerous. Or, as once again, you become a bigger, wiry kid, you can damage other children. Dr. Adma: None of this is on the table. I agree with that 2 year old example. But I'm also thinking that majority of that 6 and under are between (the ages of) 5 to 6 rather than less than 3 years. Dr. Larson: Yes, I mean it is higher, but it does seem, 2 and 3 is low, but once you hit 4 it starts to. Dr. Adma: How many 2 year olds? Dr. Larson: I don't have that information across out of that. Dr. Adma: Obviously there's something to be said about 2 year olds but I think the majority of this are 5 and 6, maybe 4, but being 5 and 6. Dr. Ellermeier: You said within the 5 and 6 year olds, but I think they are asking for are appropriate. The things they are asking to be documented are reasonable. I understand the burden of having to go through prior authorization for every single one of these but unfortunately, again, not everybody in this state that's prescribing these medications for this age group is doing it appropriately. Dr. Porter: If we do change the process. Chip, I've seen you document the hell out of stuff; I've seen your	

writing.

Dr. Millhuff: That's so that hopefully I don't have to do prior authorization.

Dr. Porter: I think that if the process was really what we talked about earlier, you've got a warning that this is gonna come up; send us your note, and your note says why you're doing it. And a reasonable person reviews it. Then that's all there is to it. There's not a phone call and there's not a bunch of extra paperwork. In which case again, that will help weed out the people that we are talking about. That aren't doing the right thing. They won't have it in their note or they won't send it in. And then instead of just sending them a letter, we have a process where it actually affects them continuing to be able to do it.
If they're not willing to document or provide documentation.

Dr. Larson: So would the suggestion be, that if we were to send a letter, that says, basically, in a sense, prior authorization criteria would be turned on, on a given date, 30 to 60 days in advance, here's a list of patients that have been identified, that would, at this point in time, be under this criteria, have to be on the front side, to provide that documentation, to basically have the prior authorization criteria. Then when that's not accomplished, then when they go to have it filled, that's when the prior authorization would kick in for the denial. Is that what I'm understanding?

Dr. Porter: I'm looking for some process like that. Other than these guys having to track down somebody.

Dr. Millhuff: For the new dose optimization program, it takes my nurse about 30 minutes to fill this stuff out, and then you've got to send it in. Many of them have been denied, and then you have to go through the process of getting ahold of other people to get it approved. And to have to do that on all these guys, if they could just read my note, like, I've had a couple of physician reviewers call me and they've already looked at my notes, they've already done it and there's some questions. I'd be more interested in that. We've spent all this time doing this collaborative documentation. Trying to get all the things hit. Why can't we make use of the existing notes for your review to make sure everything is getting hit? And I think, also, it's important as we're thinking about this, how can we educate, me and others as to what are the expectations, so that people can kind of, maybe get it together who maybe are way out of bounds for some of these sort of things.

Dr. Melton: The things we've asked for here, we were purposely trying to avoid a huge burden of what you would have to submit on a PA. Because literally if you can put a diagnosis on a form and provide us with a copy that shows labs have been done. Really that's all that we are asking for. We understand the idea that it's a burden in terms of having to do it, but what we were looking to avoid, was the things that we're asking for as a part of that PA, being excessively cumbersome. Try and tell us all these other medications you've tried, blah, blah, blah, x, y, z. We're really are trying to make it straight forward. So that you could, if you've got it in your notes; you've got a page that shows diagnosis; you've got a page that shows labs done. That's it. You're done.

Ms. Cobb: So would this be a different type of PA form? Because all the forms I'm familiar with describe exactly what you've just said.

Dr. Larson: No. The PA form would be just with this criteria which we're presenting.

Dr. Klingler: So, how does that make sure that the prescribing is appropriate if the documentation about the rationale for prescribing isn't there?

Dr. Larson: It would be in accordance with these; as was stated with these, prescribed by a psychiatrist, is one of these diagnoses, and the documentation of the screenings is going on.

Dr. Melton: So it's weeding out those cases where we have a nurse practitioner in western Kansas, who is prescribing this for a kid without a diagnosis, and then not monitoring.

Dr. Porter: And I think whoever it is prescribing antipsychotics to a 2 year old probably should be explaining why. Explain that to somebody.
Dr. Millhuff: Sure.

Dr. Porter: I heard Mike talking about giving them a Risperdal to help with attachment issues; something about Prolactin. It's reasonable to expect somebody to explain that.

Dr. Millhuff: I can't remember ever prescribing a 2 year old an antipsychotic medicine. I am getting referrals for people that are 2 years old. And the pressure is on. I'm pretty experienced with this and I can imagine other prescribers that are being pushed way outside their comfort zone. I think that's what we are kind of concerned about.

Dr. Klingler: And I think, some of this too, is there's not enough access to mental health. I mean that's the underlying problem. And I think because there's not access in a timely manner, some of these primary care physicians are probably trying to muddle through and use some of these drugs that are better served by being used by a psychiatrist but, putting more burden on the few pediatric psychiatric providers we have, may have a more detrimental problem there. We reduce access to them, that's going to fuel the need for people who don't have the experience to try and help these families. And I think there may be an unintended consequence there. I agree, 2 year olds, if they are going to be on medication, need to be seen by a pediatric psychiatrist. I have no problem, with the psychiatrist or neurologist, developmental pediatric be the adjunct prescribers, but I also don't want to cut the limited access we currently have by putting burdens on those practices.

Dr. Larson: And that's one of the things we looked at in terms of just putting the psychiatrist on the age 6 or younger and not including it on the 7 to 13.

Dr. Moeller: Just for clarification, is it just the atypicals?

Dr. Larson: Yes.

Dr. Moeller: So could a psychiatrist then decide to get around this by using more typicals?

Dr. Larson: It could be. When I was looking through information of what other states have pushed their focus, most, actually all the criteria I looked at for children was surrounding atypicals.

Dr. Porter: I think kudos to the people that put this together. This criteria is more safety based. Some could have had ultimate cost based. It could have been a factor for some states. Again, kudos, that that's not a big part of our decision making process here.

Dr. Millhuff: Has there been any thought, ideas around, the titration pace? Putting limits on that? Because one of the things that I've picked up on is preschoolers for instance, that are given starting doses more appropriate for an adult. And I'm more worried about that. I think I'm equally worried about that. I know there's some talk about dosing limits and so forth. I think it would be a good thing we need to get a hard stop. Would be if you want to start a preschooler on a dosage that's too high. And there are some guidelines for that.

Dr. Larson: And we did start, as you'll see on the next criteria, we just started with the overall, which would be for both children and adults dosing limits. And a lot of states have come up with separate for 18 and under, and some have actually done for age ranges. So under 6 is one particular dosing limit, from 6 to 10 is a separate. So that's something we can definitely look for in the future.

Sec. Mosier: As for this titration pace, you said there's clinical guidelines, if you could send those to us, we could put it into document like this for consideration next time.

Dr. Millhuff: I will get that for you.

Dr. Adma: If you look at the process, so if I am a psychiatrist writing a prescription for an antipsychotic. this say diagnosis, sure, the next is the glucose, lipid, so I write the order for labs requisition, and, by the way, they might have gone last week to the pediatricians office; they might have had the labs there, so I don't write a prescription for that because they said they just got it. So just for sheer coordination of somebody in our office, or maybe with the PCP, getting those labs on that sheet for the prior authorization process all of that process, would the MCOs, if they got the labs done; would they have access to it so that way we don't have to put it on in?

Dr. Melton: The issue with that is around the billing of it. Pharmacy claims are real time. The pharmacy

	submits it and we've pretty much got the data immediately. But you have a patient start on medication; they go to the pharmacy that day. Say they get their labs done that day too. The pharmacy claim will show up immediately. Depending on when that lab company bills, as a medical claim, we could see it not for another 60 to 90 days. So that's the issue with that. Dr. Adma: So what do we do, as psychiatrists, in those situations? Because 30 days is going to come by quickly and sometimes we can't even get it in 30 days. Dr. Ellermeier: What if, instead on providing us a specific glucose and lipid values, just simply that it's been done and then providing the height, and weight, and BMI? Because you would have those numbers without a lab draw. Dr. Adma: Which means we would have to contact the PCPs office, right? Dr. Ellermeier: The purpose of that, instead of providing us specific glucose and lipid values; you just say, this is being done either by your office or by the PCP and then providing the weight and height information. That takes out the documentation part. Dr. Melton: And I think that is acceptable to us. We're not looking for specific numbers. I mean, we understand that if you get a huge glucose reading you are going to do something about it. We're just asking that you show that it's being done. So if you were able to say, referred patient to xyz primary care provider for labs, I would think that would be adequate documentation. Dr. Adma: I think there might be so many people out there who will not. Dr. Porter: We should all be weighing. I think that's fair, a psychiatric clinic or certainly primary care. Primary care is always way ahead of us. You didn't just invent weighing patients like we did. But we should be weighing and knowing the height of our patients. Ms. Cobb: Yeah, I think we all know that hyperlipidemia, obesity, diabetes, are all real effects of these medications and especially in the child population that needs to be a priority. It's gone along with the medication started with educating our patients and thinking on that level. We already have certain medications, I'm thinking of like Clozaril clinics, that type of stuff, those two things go hand in hand, maybe if we just put these hand in hand more and share the seriousness of that with all involved in the care of the child. Dr. Melton: We understand that we're asking you guys to do things differently. It is a change. It may require you to work through a few more steps, or to have a relationship with the primary care office. But what we're trying to get at here is what is fundamentally reasonable and sound, clinically, for these patients. I think it's been touched upon a few times, but I do think we have to be mindful of, you are the good prescribers, you are	

	the ones who think about these things and it's really difficult to oversee these patients' care without having to require quote, unquote good prescribers to be part of that process. Dr. Adma: The big challenge, because I work with the foster care population they keep moving from place to place. Dr. Melton: The foster care population, we've actually been looking at some of their mental health data as well and they have higher rates of glucose and lipid screenings than your non foster care kid, who is also on an atypical antipsychotic. Which we were totally floored by, because we figured there's so much disconnection, but their rates are significantly better than the non-foster care kid in terms of both glucose and lipids. Dr. Klingler: That's because of with every new placement they have to have a new KBH done. Dr. Melton: That's why it's…. Dr. Klingler: So those kids could be getting 5 or 6 physicals a year. Dr. Melton: And that's what the psychiatrist we worked with told us. Dr. Moeller: Yeah, it's every placement they get a new physical. Sec. Mosier: We do want to be respectful of your time. We have one more policy to go through. But I kind of wanted to recap some of the things on this criteria. We talked about expanding the prescriber definition to include the developmental pediatricians, neurologists, and as the previous, the collaborative or consultative work. Potentially expanding diagnoses so there were some suggestions here, if you would, please, send in that information to Liane and Kelley as far as what you would like to see in terms of changes to the policy. We talked about changing the documentations so it was just that a glucose and lipid screening were done or a referral was made and that height and weight be documented. So that would be a change that we could consider making. There's concern over the 30 day override and potentially increasing that on recommendation on what you feel would be appropriate on that. And again, additional data as well. Then really about, how do we make this a simple process so potentially sending in just preexisting documentation that would meet this criteria. Not having to fill out a form that takes your staff 30 minutes because we want your time spent on patients and your staffs time spent on patients. And the patient safety we want time spent on that but not filling out paperwork for us. Dr. Melton: If it would be helpful, we could maybe mock up a draft form also. If that would be something that would help you guys conceptualize the process. Sec. Mosier: Certainly and bring it back for the next meeting. We would send it out ahead of time for review.	

<table>
<tr><td></td><td>So we'll go to the Antipsychotic Dosing Limits. The third set of criteria.</td><td></td></tr>
<tr><td>IV. Antipsychotic Dosing Limits</td><td>
CRITERIA FOR ANTIPSYCHOTIC DOSING LIMITS:
• Dose must not exceed limit in table 1

Table 1
<table>
<tr><th>Drug</th><th>Maximum Daily Dose</th></tr>
<tr><td>Aripiprazole (Abilify®)</td><td>30mg</td></tr>
<tr><td>Asenapine (Saphris®)</td><td>20mg</td></tr>
<tr><td>Brexpiprazole (Rexulti®)</td><td>4mg</td></tr>
<tr><td>Clozapine (Clozaril®, Fazaclo®)</td><td>900mg</td></tr>
<tr><td>Iloperidone (Fanapt®)</td><td>24mg</td></tr>
<tr><td>Lurasidone (Latuda®)</td><td>160mg</td></tr>
<tr><td>Olanazapine (Zyprexa®, Zyprexa Zydis®)</td><td>30mg</td></tr>
<tr><td>Olanzapine/Fluoxetine (Symbyax®)</td><td>18/75mg</td></tr>
<tr><td>Paliperidone (Invega®)</td><td>12mg</td></tr>
<tr><td>Quetiapine (Seroquel®)</td><td>1200mg</td></tr>
<tr><td>Quetiapine Fumarate (Seroquel XR®)</td><td>1200mg</td></tr>
<tr><td>Risperidone (Risperdal®, Risperdal M-Tab®)</td><td>16mg</td></tr>
<tr><td>Ziprasidone (Geodon®)</td><td>240mg</td></tr>
</table>
Dr. Porter: You know one thing I'd have to say back to the safety thing. I suppose if we are going to set some sort of limits, we should go back and look at the typicals. I mean, if higher dose of some of the typicals are ok. Anyway, we should look at typicals doses too.

Dr. Larson: In preparing this criteria, we did look at the typicals as well. I find it much more difficult, I guess not being in the mental health arena, to find a consensus in terms of what the upper limit would be. I'm sure there was. We did have quite a bit of discussion around that. It just did appear when looking at different sources, and also different states, that it was just much more clear in terms of the typicals, sorry, the atypicals so that's what we started with.

Dr. Porter: Well, everybody's heard a lot from me today. Did everybody get Dr. Grinages' email, comments on this topic? He could speak to us on the subject. Dr. Grinage is the other psychiatrist on the committee, he couldn't make it today. Liane you saw it didn't you?
</td><td>No formal action was taken on the proposed criteria.</td></tr>
</table>

Dr. Larson: Yes.

Dr. Melton: I don't think everybody was CC'd on it though.

Dr. Porter: Ok. Well, instead of me speaking for me, I'll speak as him, how's that? He doesn't have any cool accent that I have to mess up.

Sec. Mosier: Do you want this to read from?

Dr. Porter: Ok. Thank you. Dr. Grinage works at the Veterans Administration Hospital and also has a forensic practice in other words; he's in court a lot with psychiatric cases. He recommends, he says; "Routinely I see Quetiapine at 1500, Ziprasidone at 320." And I see, personally I would say a little bit more of the Ziprasidone at 320 and he also thinks the Abilify should be 60. And the thing is, on our form, we have several medications that are held at their package insert dosing and several that it's about, recommended about a third higher be approved. And it has to do with length of time in the field, as far as I can tell. That the longer it's been out and we're seeing what clinicians do. So the ones that are recommended to; and I should say the name of the drug that I'm on the drug company. Actually I won't speak to things that I'm on the pharmaceutical speaker's bureau for, but I'll just say that there are several of the newer ones that were being held at the PDR dosing. And it gets back to; what happens with that patient I mentioned earlier, that they're having somewhat of a response to a medication but they're at the maximum PDR dose. Whatever you do next, first you can say; that's good enough, that's all you get, or you can add Depakote which is FDA approved for adding in this situation. Some reason that doesn't work. The next thing you do; whatever you do next is going to be off label. You're either going above the PDR on that medication, because you think; they've tolerated and doing some good or you're going to say I can't go above the PDR, I'm going to add a second antipsychotic and then you get into polypharmacy. So my thought would be that we, especially given some of the more severe, this could be just for people with schizophrenia and schizoaffective disorder. That we just go ahead and say across the board, thinking that eventually some of the medications would need higher doses that we go ahead and set the bar a little bit higher. People coming out of hospitals on higher doses than some of these. Those are Dr. Grinage's thoughts and mine as well.

Sec. Mosier: Two things. Stepping back, what we'll do, just briefly, the presentation on it in terms of up to those dosing limits, that the drugs would require no prior auth. to that maximum dose, and then it's prior auth. above that. Is there anything else you'd like to add?

Dr. Larson: So this was, as you can see up here that this is the limits that we've proposed. Basically, how we came to these limits was by compiling data from other sources, other states that are already doing it. So just kind of, for some background information in terms of these recommendations, as you'll see, some of the states varied on some, some don't. For instance on Abilify the recommended dose, max dose, within both Facts and

	Comparisons, Up To Date, and all other states where they set a limit, is 30mg, so that's where the limits that we propose were set. So as you can see here, trying to get as much information as I could in terms of what is already out there being done. Dr. Melton: We erred on the side of a higher dose. Dr. Larson: Yes. Dr. Melton: Where there wasn't a consensus. Dr. Porter: Yes, you did. Dr. Ellermeier: Do we have any; is there any data at this point, of how many patients would be above these limits? Dr. Larson: Yes. For the first quarter, again, running the information, we had 128 approximately. Dr. Ellermeier: And we don't know what specialty at this time. Dr. Larson: No we do not. It was not a large in comparison to others. But, yes, the 128 were over the recommended dosing, approximately. Dr. Ellermeier: So for those 128 patients are we proposing there's no work around for them to get above the dose or would there be a prior authorization where they would do a peer-to-peer or something if they want to prescribe above that limit? Dr. Larson: At this particular time, with the way the criteria is written, there is nothing. However that line could be, at the recommendation of the committee, if that it would be sufficient to have a peer-to-peer above those doses. Dr. Porter: It's an area where we don't have science to guide us. One reason that you; when the level is held at that, so somebody is on Ziprasidone and they can't get more then 160mg or something, then sometimes, so you don't go higher, even if that might be what you want to do. Rather than add in Quetiapine on top of that Ziprasidone. A lot of it is because the clinician and the patients don't really have a choice. It falsely kind of lowers the dose you use and contributes polypharmacy. Actually, that's just my opinion. I don't think there's a consensus on this topic. I would be for, because I'm more on the side, that I would rather see people go a little bit above the book on one med than adding a second antipsychotic in, because they're not allowed, won't be paid for. I can't say I represent the entire profession. That's my opinion.	

	Dr. Adma: I think that I agree with your approach in terms of needing a process where the physician, practitioner could have some kind of a review. We're not talking about a lot of patients, right? We're talking about a very, very small number of patients, but we just need to have a process where if they want to go above those limits, there's a process. Again, all we are looking at patients admitted into state hospitals, the SMI population, probably been tried on everything we possibly could think of. Dr. Larson: So would it be appropriate within this to have the statement of: a dose must not exceed limit in table one but for approval a peer-to-peer consult would be appropriate for these patients? Dr. Porter: I guess it's only 128 cases; I can't make the claim that it's going to interfere greatly with our ability to deliver care if we go with this. If that's accurate. I would say that, the main thing I think we're debating is not as much the criteria as the process. Again, if it's a similar process whereby if I have somebody on 1500 of Seroquel, I sure better be explaining why. I should be anyway. And then if we can send that in. I think that'd be reasonable. Again, I can't argue with 128 cases statewide, that's not that many. Dr. Moeller: I agree. I think that the doses she's come up with are pretty reasonable. I can see where probably Seroquel, Quetiapine, may have a little more. Dr. Porter: The 320 mark on… Dr. Moeller: Fluoxetine and maybe Ziprasidone, I'm not exactly sure about Abilify, but I do agree, I mean, with what you were talking earlier, with the 20% reduction, that sometimes we do have to go above the max, and I think the ones that aren't above the max it is because of clinical experience. It is because of the data we have out. The newer ones, we don't know. Dr. Melton: And we can always revisit those. That's the other thing. Nicole could tell you, having been involved with DUR, in any DUR meeting we will have 4 or 5 agenda items that are just for revisions. A drug has new indications or there's new evidence for something. So you know the things we talk about and the things we decide are not set in stone and can never change. If there becomes new clinical evidence with the new drugs that are out, we can completely revisit that to make sure that we're not missing anything. We don't want to have guidelines that are horribly out of date with what's actually happening in practice. Dr. Porter: This is a follow up, I think to what Chip said, and again, this has been very collaborative, and I want to keep everybody and I think that's great. You know our practices are being brought into question, with this is about clinicians. Once this all goes through the DUR, and it's approved, whatever we come up with, what happens if, say, accidently or whatever, the MCOs have prior auth, or other behaviors outside of what we've agreed upon, do they get fined? Do they get a letter that they're doing something? What's the teeth to what we come up with?	

	Dr. Larson: Anything that gets, after this is, goes through the DUR, and is approved. Anything then that they would have sent or put in to place, is approved by us. Everything comes through for approval. So just as we recently went through the dose optimization process. Those were decided upon and then anything that was sent out to you as providers then was approved by the state. Now we do monitor, like I said with the reports, to see how things are going. I wouldn't be able to speak in terms of fining them. Dr. Melton: We'll do periodic audits on their PAs and other things. The last time we did it, we just requested a random day. We looked at all the PAs that they had reviewed for that day. So the ones that had been denied, we had them pull specific cases and then we looked to make sure; are you using the States criteria as you're supposed to be. The things we ask of them in Kansas are quite a bit different than they have in the other states they work in, because we do require them to go through our DUR board and utilize our criteria. So Kansas is already programmed to be the outlier, in terms of you can't just pull up United's standard criteria and run with it, you have to use the Kansas specific criteria. But the providers and the drug companies have been really good about telling us: "Hey, you know, we have a question about how this criteria is being applied. Is it in line with your intent? That this has this gone to DUR." We'll review that on a case by case level, and clarified to the MCOs if they are asking for a lab value the wrong way or something like that. So that we can get it addressed, so it does become a communication thing, but, thankfully, we've got really good MCO partners and we've got pharmacy departments at the MCOs. And their medical directors that understand what we are trying to do here. And we've had very few incidents like that. And worst case scenario, we get Susan's office involved and there are corrective actions. Dr. Porter: That's the teeth, not that it would ever get to that point. There's a lot of things at play, including a lot of money involved. So it's good to know. Sec. Mosier: So, on this one, are there any changes to the maximum daily dose that you would like to recommend on any of the medications? Dr. Porter: Again, I think I'm repeating my testimony. I like them being a little higher. I think the Geodon; I would. But when you show all the other states are doing it that way and there's only 128 patients, I'll defer my arguments some as long as the process is made more reasonable. Dr. Moeller: I like as is. Dr. Adma: Yeah, we'll keep them as is, but we will have the prior authorization process. Dr. Larson: So you would have me change it so for criteria for this, if dose exceeds what's listed here, then a prior authorization with a peer-to-peer consult? Dr. Porter: As the same we've talked about elsewhere would be my suggestion. We get notified, send our	

	charting in. If they disagree, then we'd have to set up a peer-to-peer consult, I guess, to tell them. Dr. Melton: So have a 30 day lead in, where you get the letter that has your patients that this would apply to? Dr. Adma: We'll go with 60 days instead of the 30 days; that gives enough time? Dr. Porter: Enough time to actually get them back in to talk to them about it. That's pretty key. Dr. Larson: Ok. Dr. Ellermeier: I agree. I think that there needs to be some notification up front. I think it's particularly important when this is put into place the first time, but then hopefully you're not seeing these; these are one ops, these are not the norm. I don't know if it would be as important, moving forward, as long as there's some provider education knowing what the limits are and that if they go above them that they need to be prepared for this process. Dr. Adma: And some of them, once they're on it, if they're stable, they're probably on it at that dose. Once they're approved, once they go through that process; for the previous ones, we put 12 months, right? Do we need to think about maybe a longer time? Once they've gone through the peer-to-peer review and approved? The 1500mg of Seroquel. Dr. Melton: We have 12 months because of the eligibility cycles. The challenge in this is, if you have patients that change MCOs a lot. They could be changing on an annual basis. But what we've seen there's not a huge amount of plan changers. A patient picks their MCO and if they're happy with them; that stays relatively consistent. But going beyond a year; that becomes part of the challenge. Dr. Adma: Thank you. Sec. Mosier: Does that accurately reflect what you were requesting, Dr. Porter? Dr. Melton: Do we need to put an approval timeframe at the bottom? That just says 12 month program approval? Dr. Porter: Same kind of language under that one that's under the other ones, I guess. I guess we need to see the actual; we've talked about changing from just a peer-to-peer phone call to another plan. I guess we'll probably get to see that in writing before we say that's what we want. Because that's what we decided. Dr. Melton: One of the things that we do is we'll review the materials that the MCOs send out to the providers. And, I mean, we'll do this with new policies in general, but specific to this Mental Health Committee, we	

	could show you guys as well all the advance notification material that providers will be receiving and have it done similarly with what we've done with dose op, where it's more coordinated. You get the letter in advance, and then we could send out the member specific letters with the names. So if you guys have thoughts on actual implementation, we're open to feedback. We do want it to be as seamless as possible. Sec. Mosier: So any other comments on any of the criteria we have? We'll get those changes made, that data, that information out in a proposed form as well. We will go over these at the next meeting as well as our next category which is taking medications by category. Dr. Larson: That's not been decided yet, but most likely. Sec. Mosier: Any other comments before we adjourn? Alright, well thank you very much. We are adjourned.	
V. Adjourn	The meeting was adjourned at 12 Noon. The next meeting will be October 28, 2015 at the HP Enterprise offices located at Forbes Field, Topeka, KS.	